TITLE 89: SOCIAL SERVICES
CHAPTER I: DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
SUBCHAPTER b: ASSISTANCE PROGRAMS

PART 125
CHILDREN'S HEALTH INSURANCE PROGRAM

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AUTHORITY: Implementing and authorized by the Children's Health Insurance Program Act [215 ILCS 106] and Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/12-13].

SOURCE: Adopted by emergency rulemaking at 22 Ill. Reg. 15706, effective August 12, 1998, for a maximum of 150 days; adopted at 23 Ill. Reg. 543, effective December 24, 1998; emergency amendment at 24 Ill. Reg. 4217, effective March 1, 2000, for a maximum of 150 days; amended at 24 Ill. Reg. 11822, effective July 28, 2000; amended at 26 Ill. Reg. 12313, effective July 26, 2002; emergency amendment at 26 Ill. Reg. 15066, effective October 1, 2002, for a maximum of 150 days; amended at 27 Ill. Reg. 4723, effective February 25, 2003; emergency amendment at 27 Ill. Reg. 10807, effective July 1, 2003, for a maximum of 150 days; amended at 27 Ill. Reg. 18623, effective November 26, 2003; emergency amendment at 28 Ill. Reg. 7163, effective May 3, 2004, for a maximum of 150 days; amended at 28 Ill. Reg. 13632, effective September 28, 2004; emergency amendment at 30 Ill. Reg. 535, effective January 1, 2006, for a maximum of 150 days; amended at 30 Ill. Reg. 10328, effective May 26, 2006.

SUBPART A: GENERAL PROVISIONS

Section 125.100 General Description

This Part implements the Children's Health Insurance Program Act [215 ILCS 106] that authorizes the Department to administer an insurance program to assist families in purchasing health insurance benefits. The Program is not an entitlement. The Program will enable eligible residents of Illinois, to the extent funding permits, access to health benefits coverage. The Department shall provide health benefits coverage to eligible individuals through purchasing or providing health care benefits or by subsidizing the cost of privately sponsored health insurance, including employer-based health insurance.

(Source: Amended at 30 Ill. Reg. 10328, effective May 26, 2006)

Section 125.110 Definitions

For the purpose of this Part, the following terms shall be defined as follows:

"Act" means the Children's Health Insurance Program Act [215 ILCS 106].

"Caretaker Relative" means a relative as specified in this definition, with whom the child lives, who is providing care, supervision and a home for the child. Caretaker relatives include:

Blood or adoptive relatives within the fifth degree of kinship:

father and mother

brother and sister

grandmother and grandfather (including up to great-great-great)

uncle and aunt (including up to great-great)

nephew and niece (including up to great-great)

first cousin

first cousin once removed (child of first cousin)

second cousin (child of great-aunt/uncle)

Step relatives:

step-father and step-mother

step-brother and step-sister

A person who is or has been married to one of the above relatives.

"Department" means the Department of Healthcare and Family Services and any successor agencies.

"Eligible Adult" means an individual 19 years of age or older who is a parent or other caretaker relative and that individual's spouse if they reside together.

"Family" means the child applying for the Program and the following individuals who

live with the child:

The child's parents

The spouse of the child's parent

Children under 19 years of age of the parents or the parent's spouse

The spouse of the child

The children of the child

If any of the above is pregnant, the unborn children.

"FamilyCare" means expansion of coverage to include eligible adults as permitted by the KidCare Parent Coverage Waiver.

"Federal Poverty Level" means the federal poverty income guidelines as established by the federal Department of Health and Human Services and published in the Federal Register.

"KidCare/FamilyCare Health Plan" means the health benefits coverage containing cost sharing features that is available to eligible families under the Children's Health Insurance Program or the KidCare Parent Coverage Waiver, and includes KidCare/FamilyCare Share (no premium required) and KidCare/FamilyCare Premium (premium required).

"KidCare/FamilyCare Rebate" means the program under which the Department, on behalf of an eligible individual, makes rebate payments to offset a family’s cost of insuring an individual under privately sponsored or employer-based health insurance.

"Medical Assistance" means health care benefits provided under Article V of the Illinois Public Aid Code.

"Program" means the program created under the Children's Health Insurance Program Act and this Part.

"Rebate" means the payment made by the Department under KidCare Rebate.

"REV" means the Recipient Eligibility Verification system through which medical providers can obtain eligibility and claim status information electronically.

"Significant Health Insurance" means coverage that includes physician services and

inpatient hospital services that would qualify for coverage under KidCare Rebate.

(Source: Amended at 30 Ill. Reg. 10328, effective May 26, 2006)

SUBPART B: GENERAL ELIGIBILITY AND ENROLLMENT

Section 125.200 Eligibility for Children's Health Insurance Program and FamilyCare

A child or eligible adult may be eligible under the Program provided that all of the following eligibility criteria are met:

a) The child or eligible adult is not eligible for Medical Assistance including Section 120.32.

b) The child is under 19 years of age.

c) Countable Income

1) A child is a member of a family whose monthly countable income is above 133 percent of the Federal Poverty Level and at or below 200 percent of the Federal Poverty Level.

2) An eligible adult is a member of a family whose monthly income is above 133 percent of the Federal Poverty Level and at or below 185 percent of the Federal Poverty Level.

d) The individual is a resident of the State of Illinois.

e) The individual is either a United States citizen or included in one of the following categories of non-citizens:

1) United States veterans honorably discharged or individuals on active military duty, or the spouse or unmarried dependent children of such persons.

2) Refugees under Section 207 of the Immigration and Nationality Act.

3) Asylees under Section 208 of the Immigration and Nationality Act.

4) Individuals for whom deportation has been withheld under Section 243(h) of the Immigration and Nationality Act.

5) Individuals granted conditional entry under Section 203(a)(7) of the Immigration and Nationality Act as in effect prior to April 1, 1980.

6) Individuals lawfully admitted for permanent residence under the

Immigration and Nationality Act.

7) Parolees, for at least one year, under Section 212(d)(5) of the Immigration and Nationality Act.

8) Nationals of Cuba or Haiti.

9) Individuals identified by the Federal Office of Refugee Resettlement (ORR) as victims of trafficking.

10) Amerasians from Vietnam.

11) Members of the Hmong or Highland Laotian tribe when the tribe helped United States personnel by taking part in military or rescue operations.

12) American Indians born in Canada.

13) Individuals who are a spouse, widow or child of a United States citizen or a spouse or a child or a legal permanent resident (LPR) who have been battered or subjected to extreme cruelty by the United States citizen or LPR or a member of that relative's family who lived with them, who no longer live with the abuser or plan to live separately within one month after assistance and whose need for assistance is due, at least in part, to the abuse.

f) The individual's Social Security Number (SSN) is provided to the Department, or if it has not been issued or is not known, proof that application has been made for an SSN is provided.

(Source: Amended at 30 Ill. Reg. 10328, effective May 26, 2006)

Section 125.205 Eligibility Exclusions and Terminations

a) An individual shall not be determined eligible for coverage under the Program if:

1) The individual is an inmate of a public institution.

2) The individual is a patient in an institution for mental diseases.

3) The individual is a member of a family that is eligible for health benefits coverage under a State of Illinois health benefits plan on the basis of a member's employment with a public agency.

4) The individual is in categories described in Section 125.200(e)(6) or (e)(7), and the individual entered the United States on or after August 22, 1996; he or she shall not be eligible for five years beginning on the date the individual entered the United States.

b) An individual with significant health insurance can choose between KidCare/FamilyCare Health Plan and KidCare/FamilyCare Rebate.

c) Termination of an individual's coverage under the Program shall be initiated upon the occurrence of any of the following events:

1) A child becomes ineligible due to:

A) Losing his or her Illinois residency.

B) Attaining 19 years of age.

C) Becoming enrolled in Medical Assistance.

D) Meeting the provisions of subsection (a)(1) or (a)(3) of this Section.

2) An eligible adult becomes ineligible due to:

A) Losing his or her Illinois residency.

B) No child under 19 years of age remaining in the family.

C) Becoming enrolled in Medical Assistance.

D) Meeting the provisions of subsection (a)(1) or (a)(3) of this

Section.

E) Income exceeding the range established in Section 125.200(b)(2).

3) A child or an eligible adult becomes ineligible due to:

A) The required premiums under the KidCare/FamilyCare Health Plan are not paid as specified in Sections 125.320 and 125.330.

B) An individual enrolled in KidCare Rebate is no longer being covered under a private or employer-based health insurance plan, except that an individual may change enrollment from KidCare/FamilyCare Rebate to the KidCare/FamilyCare Health Plan pursuant to Section 125.260(c).

C) The individual fails to report to the Department changes in information that impacts upon the individual's eligibility for the Program.

D) The individual makes a request to the Department to terminate the coverage.

E) The Department determines that the individual is no longer eligible based on any other applicable State or federal law or regulation.

F) The Department determines that the individual failed to provide eligibility information that was truthful and accurate to the best of the applicant’s knowledge and belief and that affected the eligibility determination.

G) There has been a Rebate overpayment and it has not been repaid to the Department according to terms established by the Department, which may include recoupment out of future Rebate payments or a payment plan.

H) The Department determines that the individual's eligibility was incorrectly determined.

I) The application was approved pending receipt of the individual's Social Security Number and it is not provided later when requested.

d) Following termination of coverage under the Program, the following action is

required before the individual can be re-enrolled:

1) A new application must be completed and the individual must be determined otherwise eligible;

2) There must be full payment of premiums under the KidCare Health Plan, for periods in which a premium was owed and not paid for the individual, including premiums owed when the individual was, for purposes of this Part, a member of another family;

3) Any overpayment of Rebates paid on behalf of the individual must be repaid to the Department. A Rebate overpayment shall be considered repaid if the Department can recoup the overpayment out of future Rebate payments;

4) If the termination was the result of non-payment of premiums, the individual must be out of the Program for three months before re-enrollment; and

5) The first month's premium must be paid if the individual is eligible for KidCare/FamilyCare Premium and the individual's family chose to have coverage under subsection (g) of this Section when the individual was initially enrolled in the Program or if there was an unpaid premium on the date the individual's previous case was canceled.

e) An application will be denied if any of the eligible adults in the family was responsible as a caretaker relative or eligible adult during a period for which a premium under the Program was due to the Department and the premium remains unpaid at the time of application. Such an application shall be denied regardless of whether the individual for whom the premium remains unpaid is included in the application.

f) An application will be denied if any of the eligible adults received benefits or was a caretaker relative of a child during a period for which a Rebate overpayment was received or was the payee of a Rebate overpayment and the overpayment has not been repaid to the Department. Such an application shall be denied regardless of whether the individual for whom the Rebate overpayment remains unpaid is included in the application.

g) A certificate of prior creditable coverage will be issued when the individual's coverage is terminated under the KidCare/FamilyCare Health Plan.

(Source: Amended at 30 Ill. Reg. 10328, effective May 26, 2006)

Section 125.220 Application Process

a) Families will be able to apply for the Program using any of the following methods:

1) Submit the Department's application to an address specified by the Department.

2) Apply at a Department of Human Services (DHS) local office.

3) Apply through a KidCare Application Agent that has an agreement in place with the Department.

4) Apply online at www.kidcareillinois.com

5) Additional methods that the Department establishes.

b) The application will meet all requirements found at 89 Ill. Adm. Code 110.10.

c) Families are obligated to provide truthful and accurate information for determining eligibility and to report promptly to the Department any change in non-financial information provided on the application or financial information for eligible adults.

d) The Department may cease accepting or processing applications if enrollment in the Program is closed due to limited appropriations.

e) The Department shall send a notification of its determination within 45 calendar days after the date the application was received.

f) The 45 calendar days may be extended when a decision cannot be reached because:

1) information necessary for a determination is available only from a third party and the party fails to respond or delays his or her response to the request for such information, or

2) additional information is needed from the applicant.

(Source: Amended at 30 Ill. Reg. 10328, effective May 26, 2006)

Section 125.225 Presumptive Eligibility for Children

a) A child younger than 19 years of age may be presumed eligible for a KidCare Health Plan under this Part if all of the following apply:

1) an application for medical benefits has been made on behalf of the child;

2) the child is a resident of Illinois;

3) the child is not an inmate of a public institution as described in Section 125.205(a)(1);

4) the child is a member of a Family whose monthly countable income, as stated on the application, is above 133 percent of the Federal Poverty Level and at or below 200 percent of the Federal Poverty Level;

5) the State employee who registers the application has no information that the child is not a U.S. citizen or a qualified non-citizen as described in 89 Ill. Adm. Code 125.200(e) or 89 Ill. Adm. Code 118.500; and

6) the child has not been presumed eligible under this Part 125 or 89 Ill. Adm. Code 118 or 120 within the past 12 months.

b) Entities qualified to make a determination of presumptive eligibility include State employees involved in enrolling children in programs under this Part 125 or 89 Ill. Adm. Code 118 or 120.

c) The presumptive eligibility period begins on the date of application.

d) The presumptive eligibility period ends on the date the State's determination of the child's eligibility under this Part 125 or 89 Ill. Adm. Code 118 or 120 is updated in the data system.

e) No copayment or premium requirements apply during the period of presumptive eligibility.

(Source: Added at 28 Ill. Reg. 13632, effective September 28, 2004)

Section 125.230 Determination of Monthly Countable Income

a) Monthly countable income for applications processed for the Program is determined by taking the total gross monthly income of the family and subtracting allowable deductions and exemptions as described in 89 Ill. Adm. Code 120, Subpart H.

b) For the purpose of subsection (a) of this Section, the number of individuals in the family determines the applicable income standard.

(Source: Amended at 30 Ill. Reg. 10328, effective May 26, 2006)

Section 125.240 Eligibility Determination and Enrollment Process

a) If the monthly countable income is at or below 133 percent of the Federal Poverty Level for the number of individuals in the family, the individual will be enrolled in Medical Assistance, if otherwise determined eligible pursuant to 89 Ill. Adm. Code 120, Subpart H.

b) If the monthly countable income is above 133 percent and at or below 200 percent of the Federal Poverty Level for a child, or at or below 185 percent of the Federal Poverty Level for an adult, for the number of individuals in the family, and all other eligibility requirements of this Part are met and enrollment is open, the individual will be enrolled in the Program.

c) For purposes of cost sharing, families in the KidCare/FamilyCare Health Plan will be enrolled into either KidCare/FamilyCare Share or KidCare/FamilyCare Premium as follows:

1) If monthly countable income is above 133 percent and at or below 150 percent of the Federal Poverty Level for the number of individuals in the family, the individual will be enrolled in KidCare/FamilyCare Share.

2) If monthly countable income is above 150 percent and at or below 200 percent of the Federal Poverty Level for the number of individuals in the family, a child will be enrolled in KidCare Premium or, if monthly countable income is above 150 percent and at or below 185 percent of the Federal Poverty Level for the number of individuals in the family, an eligible adult will be enrolled in FamilyCare Premium.

d) Applicants will be notified, in writing, regarding the outcome of their eligibility determination.

e) Eligibility determinations for the Program made by the fifteenth day of the month will be effective the first day of the following month. Eligibility determinations for the Program made after the fifteenth day of the month will be effective no later than the first day of the second month following that determination. The duration of eligibility for the Program for children will be 12 months unless one of the events described in Section 125.205 (c)(1) or (c)(3) occurs. The 12 months of eligibility will commence when the first child in a family is covered under the Program. Children added to the Program after the eligibility period begins will be eligible for the balance of the 12-month eligibility period.

f) Individuals determined to be eligible for the KidCare/FamilyCare Health Plan

may obtain coverage for a period prior to the date of application for the Program. This coverage shall be subject to the following:

1) The family must request the prior coverage for the individual within six months following the initial date of coverage under the KidCare/FamilyCare Health Plan.

2) The prior coverage will be individual specific and will only be available the first time the individual child is enrolled in the Program.

3) The prior coverage will begin with services rendered during the two weeks prior to the date the individual's application for the KidCare/FamilyCare Health Plan was filed and will continue until the individual's coverage under the KidCare/FamilyCare Health Plan is effective pursuant to subsection.

Source: Amended at 30 Ill. Reg. 10328, effective May 26, 2006)

Section 125.245 Appeals

a) Any person who applies for or receives assistance under the Program shall have the right to appeal any of the following actions:

1) Refusal to accept an application.

2) Denial of an application or cancellation at the annual renewal including denial based on failure to meet one or more of the eligibility requirements specified in this Part. If the denial or cancellation is not upheld on appeal, coverage under the Program shall be retroactive to the date the coverage would have commenced had the application or annual determination been approved. However, if the individual is eligible for KidCare/FamilyCare Premium, it will be at the family's option whether coverage following a successful appeal shall be prospective only for the remainder of the 12-month period following application or retroactive to the date the coverage would have commenced had the application been approved. All premium and copayment requirements shall apply to the retroactive period.

3) Termination of coverage based on failure to continue to meet one or more of the eligibility requirements specified in this Part. If the termination is not upheld on appeal and benefits were not continued during the appeal, coverage under the Program shall be reinstated retroactive to the termination date. However, if an individual is eligible for KidCare/ FamilyCare Premium, it will be at the family's option whether coverage following a successful appeal shall be prospective only for the remainder of the 12-month period following application or retroactive to the date of termination. All premium and copayment requirements shall apply to any retroactive period.

4) Determination of the amount of the premium, Rebate, or copayments required. Coverage, Rebate amount and any premium or copayment requirements, as determined by the Department, shall remain in force during the appeal process.

b) In addition to the actions that are appealable under subsection (a) of this Section, individuals covered under the KidCare/FamilyCare Health Plan shall have the right to appeal any of the following actions:

1) Termination of coverage due to non-payment of the required premium.

2) Denial of payment for a medical service or item that requires prior approval.

3) Decision granting prior approval for a lesser or different medical service or item than was originally requested.

c) The Department's decision to deny an application due to closing of enrollment for the Program shall not be appealable.

d) Individuals may initiate the appeal process by:

1) Filing a written, signed request for a hearing directed to the Department's Assistance Hearings Section;

2) Calling a toll free telephone number (800/435-0774, or as designated by the Department).

e) The request for a hearing may be filed by the individual affected by the action or by the individual's authorized representative.

f) For purposes of initiating the appeal process, a copy of a written, signed request for a hearing is considered the same as the original written, signed request.

g) The request for a hearing must be filed no later than 60 days after notice of the appealable action has been given.

h) If an appeal is initiated within ten calendar days after the notice of intended Department action and the individual specifically requests that the benefits be continued, benefits shall be continued at the level in effect prior to the proposed action, pending the results of the fair hearing process. All copayment obligations including premiums must be met during the period.

i) The provisions of Subpart A of the Department's administrative rules at 89 Ill. Adm. Code 104, Practice in Administrative Hearings, shall govern the handling of appeals and the conduct of hearings under the Program.

j) An individual can, prior to a decision being rendered on the appeal, reapply for the Program.

(Source: Amended at 30 Ill. Reg. 10328, effective May 26, 2006)

Section 125.250 Annual Renewals

a) Eligibility shall be reviewed by the Department, or its authorized agent, at least annually.

b) Prior to the 12-month eligibility period ending, and in sufficient time for the Family to respond to the Department's request for information, the Department or its designee will send an annual renewal notice to the Family.

c) Annual renewals shall be subject to all eligibility requirements set forth in Sections 125.200 and 125.205.

(Source: Amended at 24 Ill. Reg. 11822, effective July 28, 2000)

Section 125.260 Adding Children to the Program and Changes in Participation

a) Families may add eligible children to the Program during the 12-month eligibility period, without eligibility being reviewed by the Department. Coverage for children added shall be prospective from the effective date determined according to Section 125.240(e) and shall continue for the remainder of the family's original 12-month eligibility period and may also include any prior coverage established pursuant to Section 125.240(f).

b) Premium amounts under the KidCare Health Plan and Rebates under KidCare Rebate will be adjusted to reflect adding or removing a child from the Program.

c) A child who would otherwise be terminated from KidCare Rebate because of losing private or employer-sponsored health insurance may change coverage to the KidCare Health Plan without eligibility being reviewed by the Department if there is no unpaid Rebate overpayment. Coverage under the KidCare Health Plan shall be prospective from the effective date determined according to Section 125.240(e) and shall continue for the remainder of the existing 12-month eligibility period. However, at the time of the change in coverage, a family may choose to have the KidCare Share or Premium coverage retroactive to the first day of the first month following the last month of coverage under the private or employer sponsored insurance if the family refunds within 30 days after the Department's notice that the child's coverage has been changed to KidCare Health Plan any Rebate payment received for a month in which there was no private or employer based insurance coverage, notwithstanding Section 125.445(c).

d) A child with significant health insurance may choose to change coverage from the KidCare Health Plan to KidCare Rebate without eligibility being reviewed by the Department if the family returns a Rebate form and there are no unpaid premiums owed to the Department. Coverage under KidCare Rebate shall be prospective from the effective date determined according to Section 125.240(e), following receipt by the Department of a completed Rebate Form and shall continue for the remainder of the existing 12-month eligibility period.

Source: Amended at 30 Ill. Reg. 10328, effective May 26, 2006

Section 125.265 Adding Eligible Adults to the Program and Changes in Participation

a) Families may add eligible adults to the Program during the 12-month eligibility period if the family income meets the income levels as stated in Section 125.240. Coverage for the added eligible adult shall be prospective from the effective date determined according to Section 125.240(e) and may also include any prior coverage established pursuant to Section 125.240(f).

b) Premium amounts under the FamilyCare Health Plan and Rebates under FamilyCare Rebate will be adjusted to reflect adding or removing an eligible adult from the Program.

c) An eligible adult who would otherwise be terminated from FamilyCare Rebate because of losing private or employer-sponsored health insurance may change coverage to the FamilyCare Health Plan if there is no unpaid Rebate overpayment. Coverage under the FamilyCare Health Plan shall be prospective from the effective date determined according to Section 125.240(e). However, at the time of the change in coverage, a family may choose to have the FamilyCare Share or Premium coverage retroactive to the first day of the first month following the last month of coverage under the private or employer sponsored insurance if the family refunds, within 30 days after the Department's notice that the person's coverage has been changed to FamilyCare Health Plan, any Rebate payment received for a month in which there was no private or employer based insurance coverage, except as described in Section 125.445(c).

d) An eligible adult with significant health insurance may change coverage to FamilyCare Rebate if the family returns a Rebate form and there are no unpaid premiums owed to the Department. Coverage under FamilyCare Rebate shall be prospective from the effective date determined according to Section 125.240(e), following receipt by the Department of a completed Rebate Form.

(Source: Added at 30 Ill. Reg. 10328, effective May 26, 2006)

SUBPART C: KIDCARE/FAMILYCARE HEALTH PLAN

Section 125.300 Covered Services

a) For children covered under the KidCare Health Plan, covered health care services shall be the same covered services for children as described at 89 Ill. Adm. Code 140, 77 Ill. Adm. Code 2090, and 59 Ill. Adm. Code 132, except as provided in Section 125.305, and subject to appropriation and any applicable cost sharing requirements defined in Section 125.310 and Section 125.320.

b) For eligible adults covered under the FamilyCare Health Plan, covered health care services shall be the same covered services for adults as described at 89 Ill. Adm. Code 140, 77 Ill. Adm. Code 2090, and 59 Ill. Adm. Code 132, except as provided at Section 125.305, and subject to appropriation and any applicable cost sharing requirements defined in Section 125.310 and Section 125.320.

(Source: Amended at 30 Ill. Reg. 10328, effective May 26, 2006)

Section 125.305 Service Exclusions

The following health care services will not be covered under the KidCare/FamilyCare Health Plan:

a) Services provided only through a waiver approved under Section 1915(c) of the Social Security Act.

b) Abortion services.

(Source: Amended at 30 Ill. Reg. 10328, effective May 26, 2006)

Section 125.310 Copayments

a) Copayments may be charged to the family by a health care professional whenever the service is performed in an office or home setting, except for visits scheduled for well-baby care, well-child care or age-appropriate immunizations. Copayments may also be charged to the family by hospitals, once per inpatient admission or outpatient encounter (including the emergency room). No copayment is permitted for visits to health care professionals or hospitals made solely for speech, occupational or physical therapy, audiology, radiology or laboratory services (including APL Group 2 procedures). Families with an enrolled individual who is an American Indian or Alaska Native shall not be charged copayments.

b) Copayment requirements are as follows:

1) Practitioner office visit:

A) KidCare/FamilyCare Share copayment: $2 per visit.

B) KidCare/FamilyCare Premium copayment: $5 per visit.

2) Home health care visit:

A) KidCare/FamilyCare Share copayment: $2 per visit.

B) KidCare/FamilyCare Premium copayment: $5 per visit.

3) Inpatient hospitalization:

A) KidCare/FamilyCare Share copayment: $2 per admission.

B) KidCare/FamilyCare Premium copayment: $5 per admission.

4) Outpatient encounter (including the emergency room):

A) KidCare/FamilyCare Share copayment: $2 per visit.

B) KidCare/FamilyCare Premium copayment: $5 per visit.

5) Prescription drugs:

A) KidCare/FamilyCare Share copayment: $2 for a 1- to 30-day

supply on both generic and brand name drugs.

B) KidCare/FamilyCare Premium copayments: $3 for a 1- to 30-day supply on generic drugs or $5 for 1 to 30-day supply on brand name drugs.

6) Nonemergency visit to an emergency room:

A) KidCare/FamilyCare Share copayments: $2 per visit.

B) KidCare/FamilyCare Premium copayment: $25 per visit.

c) The maximum out-of-pocket expense a family will incur for copayments during a 12-month eligibility period is $100.

d) Once the family has satisfied the copayment cap, the family is responsible for submitting receipts, to the Department, documenting the payment of copayments. The Department may return partial documentation received on copayments to the family.

e) Upon the Department determining that the copayment cap has been satisfied, the following will occur:

1) A notice stating that the copayment cap has been satisfied, and the date satisfied, will be sent to the family.

2) A message that the copayment cap has been satisfied, and the date satisfied, will be available through the family identification card.

3) REV will be updated to reflect that the copayment cap has been reached.

f) Providers will be responsible for collecting copayments under the KidCare/ FamilyCare Health Plan.

g) Providers may elect not to charge copayments. If copayments are charged, the copayment must comply with the requirements in this Section.

h) Providers shall be responsible for refunding to the family copayments they collect after the family has reached the copayment cap.

i) The Department will not require providers to deliver services when copayments properly charged under the KidCare/FamilyCare Health Plan are not paid.

(Source: Amended at 30 Ill. Reg. 10328, effective May 26, 2006)

Section 125.320 Premium Requirements

a) Families with individuals enrolled in KidCare/FamilyCare Premium pursuant to Section 125.240(c) must pay the premiums established by this Section.

b) The premium amounts are $15 for one individual, $25 for two individuals, $30 for three individuals, $35 for four individuals, and $40 for five or more individuals.

c) Premiums are billed by and payable to the Department, or its authorized agent, on a monthly basis.

d) The premium due date will be 26 days after the fifth day of the calendar month preceding the month of coverage.

e) The premium will not change during the eligibility period, unless the family adds or removes individuals from the coverage.

f) No premiums shall be charged to families with an enrolled individual who is an American Indian or Alaska Native.

(Source: Amended at 30 Ill. Reg. 10328, effective May 26, 2006)

Section 125.330 Non-payment of Premium

a) KidCare/FamilyCare Health Plan participants will have a grace period through the end of the month following the coverage month to pay the premium.

b) Failure to pay the full monthly premium by the last day of the grace period will result in termination of coverage.

c) Partial premium payments will not be refunded.

d) Collection action will be initiated by the Department to collect unpaid premiums.

(Source: Amended at 30 Ill. Reg. 10328, effective May 26, 2006)

Section 125.340 Provider Reimbursement

a) Providers under this Part shall be subject to approval by the Department to provide health care under the Illinois Public Aid Code.

b) Provider participation under this Part shall be voluntary.

c) Providers under this Part shall be reimbursed in accordance with the established rates of the Department or other appropriate State agency.

d) In addition to reimbursements received from the Department, providers may retain copayments defined in Section 125.310.

e) Providers under this Part shall be prohibited from billing families covered under the KidCare/FamilyCare Health Plan any difference between the charge amount and the amount paid by the Department, except for copayments as specified in Section 125.310.

f) Providers shall be responsible for refunding to the family copayments collected in excess of the amounts permitted by this Part.

(Source: Amended at 30 Ill. Reg. 10328, effective May 26, 2006)

SUBPART D: KIDCARE/FAMILYCARE REBATE

Section 125.400 Minimum Coverage Requirements

For an eligible individual to participate in KidCare/FamilyCare Rebate, the eligible individual must be covered by an insurance plan that offers comprehensive major medical coverage providing benefits for physician services and hospital inpatient services.

(Source: Amended at 30 Ill. Reg. 10328, effective May 26, 2006)

Section 125.420 Coverage Verification Process

a) All applications for participation in KidCare/FamilyCare Rebate must be accompanied by the Department's Insurance Rebate Form.

b) Verification of insurance coverage for the previous coverage period will be required at the annual renewal of KidCare/FamilyCare Rebate.

c) The Department, or its authorized agent, may verify insurance coverage for participants under KidCare/FamilyCare Rebate.

(Source: Amended at 30 Ill. Reg. 10328, effective May 26, 2006)

Section 125.430 Provision of Policyholder's Social Security Number

For an eligible individual to participate in KidCare/FamilyCare Rebate, the policyholder's valid Social Security Number must be provided.

(Source: Added at 30 Ill. Reg. 10328, effective May 26, 2006)

Section 125.440 KidCare/FamilyCare Insurance Rebate

a) The Rebate will be paid to the individual policyholder insuring the individual.

b) The Department will issue Rebates on a monthly basis.

c) The total dollar amount of the Rebate paid by the Department per individual per month shall be the lesser of:

1) The maximum monthly amount set by the Department calculated in accordance with the restrictions in 215 ILCS 106/25 and available appropriations, or

2) The policyholder's monthly portion of the premium paid for coverage of individuals enrolled under KidCare/FamilyCare Rebate.

d) The Department shall set the amount of the Rebate, described in subsection (c) of this Section, prospectively.

e) To be eligible for payment, a Rebate must equal at least one dollar.

(Source: Amended at 30 Ill. Reg. 10328, effective May 26, 2006)

Section 125.445 Rebate Overpayments

a) For purposes of this Part, a Rebate overpayment occurs in any of the following circumstances:

1) the monthly Rebate paid was higher than the policyholder's portion of the premium for the individuals enrolled in KidCare/FamilyCare Rebate;

2) the monthly Rebate paid per individual was higher than the maximum monthly amount set by the Department pursuant to Section 125.440(c)(1);

3) the Rebate was paid for an individual who was incorrectly enrolled in KidCare/FamilyCare Rebate due to inaccurate or untruthful information provided on the application;

4) the Rebate was paid for a period during which the individual was not covered by private or employer-based insurance meeting the requirements of Section 125.400; or

5) the Rebate was paid for an eligible adult for whom an increase in income was not reported within ten days after the change and the family's income exceeded the upper limit set at Section 125.200(c)(2).

b) Collection action will be initiated by the Department to collect Rebate overpayments.

c) In cases where the family notified the Department of the loss of insurance of any enrolled individual or the increase of income with respect to an eligible adult within ten days after the change but past the date when the Department was able to stop issuance or adjust the amount of the next Rebate, the relevant portion of the Rebate is not an overpayment.

d) In cases where an individual is covered by private or employer-based insurance (regardless of whether the coverage meets the requirements of Section 125.400) and, due to Department error, Department of Human Services error or inaccurate information from an employer or other third party, an individual is enrolled in Rebate that should not have been or a Rebate payment is higher than it would have been if properly calculated based on accurate information, no overpayment occurs, provided the amount sent in any month does not exceed the maximum monthly amount set by the Department pursuant to Section 125.440(c)(1).

(Source: Amended at 30 Ill. Reg. 10328, effective May 26, 2006)